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8	D	RE THE					
9.	BOARD OF REGISTERED NURSING						
10	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA						
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12	In the Matter of the Accusation Against:	Case No.	2010	- 00-			
13	ERLINDA ATIENZA ABRANTES, R.N. 23835 Spring Branch Court		-		•	٠	
14	Murrieta, CA 92562	ACCU	SATIO	N			
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15	Registered Nurse License No. 424649						
16	Respondent.						
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18	Complainant alleges:				,		
19	PAR	TIES					
20	1. Louise R. Bailey, M.Ed., RN (Comp	lainant) brii	ngs this A	ccusatio	n solely i	n her	
21	official capacity as the Interim Executive Officer of the Board of Registered Nursing, Departmen						
22	of Consumer Affairs (Board).		:				
23	2. On or about April 30, 1988, the Boar	d of Regist	ered Nurs	sing issue	d Registo	ered Nurse	
24	License Number 424649 to Erlinda Atienza Abra	antes (Resp	ondent).	The Regi	stered N	urse	
25	License was in full force and effect at all times relevant to the charges brought herein, and will						
26	expire on January 31, 2012, unless renewed.		: .				
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JURISDICTION

- 3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
- 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part; that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
 - 5. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

REGULATORY JURISDICTION

7. California Code of Regulations (Regulation), title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations (Regulation), title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence and/or Incompetence)

- 9. Respondent is subject to disciplinary action under section 2761(a)(1) and Regulations 1442 and 1443, in that she was grossly negligent and/or incompetent. The circumstances are as follows:
- 10. Respondent was employed as a Registered Nurse for the Department of Mental Health, Metropolitan State Hospital, Norwalk, California. On or about August 4, 2007, Respondent was the Relief AM Shift Lead. At approximately 9 a.m., Patient D.S. reported to Respondent that he was pushed down by an individual and was having pain in his right leg. Respondent was asked by C.B., the Senior Psychiatric Technician, if she was going to do an assessment and other necessary documentation of the incident. Respondent indicated that she was.
- 11. When C.B. returned to the unit at approximately 2 p.m., she discovered that the Special Incident Report and pain assessment was not completed by Respondent, nor had Respondent delegated these duties to another registered nurse. In fact, F.M., a psychiatric technician assistant, had to personally summon the doctor because Respondent did not complete her responsibilities. C.B. then instructed Respondent again to complete the Special Incident Report and pain assessment.
- 12. An x-ray of Patient D.S. was completed at approximately 5 p.m., and revealed that the patient had a fractured right hip. He was transported to LAC/USC for emergency services.
- 13. Respondent's inaction caused an unnecessary delay in the diagnosis and treatment of Patient D.S.'s hip fracture.

14. As a result of the above incident, an Adverse Action consisting of a 2-step salary reduction was filed against Respondent for violations of Government Code sections 19572(d) and (t) (inexcusable neglect of duty and other failure of good behavior either during or outside of duty hours that is of such a nature that it causes discredit to the appointing authority or the person's employment. The Adverse Action also included a July 11, 2007, incident where Respondent left a patient unsupervised on two occasions).

SECOND CAUSE FOR DISCIPLINE

- (Unprofessional Conduct Gross Negligence and/or Incompetence)
- Respondent is subject to disciplinary action under section 2761(a)(1) and Regulations 1442 and 1443 in that she was grossly negligent and/or incompetent. The circumstances are as follows:
- 16. At approximately 1:20 p.m., on or about April 14, 2008, while employed as a Registered Nurse for the Department of Mental Health, Metropolitan State Hospital, the Hospital Police Department received a call requesting assistance in Unit 412. The officers observed a patient crying and demanding to be sent to LA County/USC Hospital. The patient had a large open wound in her abdomen area. A second female patient was in the restroom screaming and banging the walls for attention.
- 17. At that time, Respondent was in Unit 412's nurse's station. When the officers approached Respondent and asked for her assistance, she refused to exit and assist the officers and the injured patient. Approximately 15 to 25 patients then entered the unit, and became agitated when they saw the officers. A patient attacked one of the officers.
- 18. The officers radioed for assistance and to report Respondent's refusal to assist. When Respondent was interviewed about the incident, she falsely stated that the officers never asked for her assistance.
- 19. As a result of this incident, an Adverse Action recommending that Respondent be dismissed from her Registered Nurse position was filed for violations of Government Code sections (c), (d), (f), (o) and (f) (inefficiency, inexcusable neglect of duty, dishonesty, willful

1	disobedience, and other failure of good behavior either during or outside of duty hours that is of					
2	such a nature that is causes discredit to the appointing authority or the person's employment).					
3	PRAYER					
4	WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,					
5	and that following the hearing, the Board of Registered Nursing issue a decision:					
6	 Revoking or suspending Registered Nurse License Number 424649, issued to Erlinda 					
7:	Atienza Abrantes;					
8	2. Ordering Erlinda Atienza Abrantes to pay the Board of Registered Nursing the					
9.	reasonable costs of the investigation and enforcement of this case, pursuant to Business and					
1.0	Professions Code section 125.3; and					
11	3. Taking such other and further action as deemed necessary and proper.					
12 :						
13	DATED: 5/28/10 Louise R. Bailes					
14	LOUISE R. BAILEY, M.ED., RN Interim Executive Officer					
15	Board of Registered Nursing Department of Consumer Affairs					
16	State of California Complainant					
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